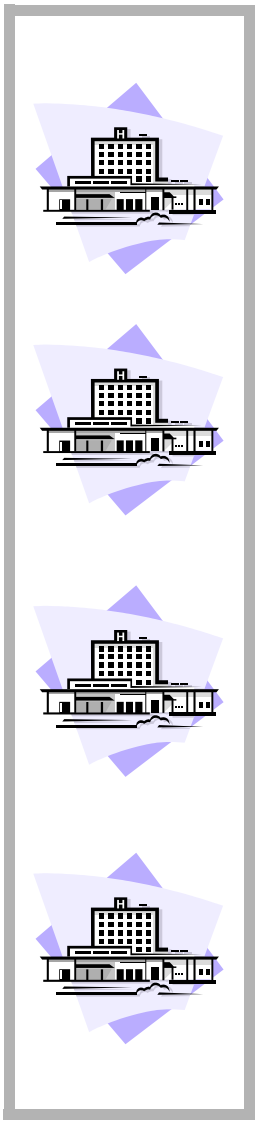

Hospital Outpatient Services

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

April 2004

This publication supersedes all previous Hospital Outpatient Services handbooks. Published by the Montana Department of Public Health & Human Services, August 2003.

Updated April 2004.

My Medicaid Provider ID Number:

Before performing a sterilization, the following requirements must be met:

- The client must have the opportunity to have questions regarding the procedure answered to his/her satisfaction.
- The client must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
- The client must be made aware of available alternatives of birth control and family planning.
- The client must understand that the sterilization procedure being considered is irreversible.
- The client must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The client must be informed of the benefits and advantages of the sterilization procedure.
- The client must know that he/she will have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for those clients who are blind, deaf, or do not understand the language to ensure the person has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the client is in labor or childbirth.
- If the client is seeking or obtaining an abortion.
- If the client is under the influence of alcohol or another substance which affects his/her awareness.

Medically Necessary Sterilization

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies, oophorectomies, salpingectomies and ochiectomies. Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one of the following:

- A completed *Medicaid Hysterectomy Acknowledgement* form (MA-39) for each provider submitting a claim. See *Appendix A Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client must sign and date section A of this form at least 30 days prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). The client does not need to sign this form when sections B or C are used. Please refer to *Appendix A* for more detailed instructions on completing the form.

- For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
  - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
  - The reason for the hysterectomy was a life-threatening emergency.
  - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

Therapy services

In an outpatient department, physical, occupational, and speech/language therapy services are limited to 40 hours each during a state fiscal year (July 1 - June 30) for adults age 21 years and older. Children may qualify for more than 40 hours if medically necessary, and prior authorization is required (see the *PASSPORT and Prior Authorization* chapter in this manual).

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

Lab and imaging services are the only hospital outpatient services available for clients enrolled in MHSP. This limit does not apply to Medicaid enrolled clients receiving mental health services. Providers will find more information on Medicaid mental health services and MHSP services in the *Mental Health* manual available on the Provider Information website (see *Key Contacts*).

Children's Health Insurance Plan (CHIP)

The information in this chapter does not apply to CHIP clients. Hospital outpatient services for children with CHIP coverage are covered by the BlueCHIP plan of BlueCross BlueShield of Montana (BCBSMT). For more information contact BCBSMT at (800) 447-7828 x8647 or (406) 447-8647. Additional information regarding CHIP is available on the *CHIP* website (see *Key Contacts*).

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements
• **Eye prosthesis** • **New technology codes (Category III CPT codes)** • **Other reviews referred by Medicaid program staff**	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953 **Phone:** For clients with last names beginning with **A - L**, call: (406) 444-3993 In/out-of-state For clients with last names beginning with **M - Z**, call: (406) 444-0190 In/out-of-state **Fax:** (406) 444-0778	• Documentation that supports medical necessity • Documentation regarding the client's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.

• **Circumcision**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Requests are reviewed case-by-case basis based on medical necessity when one of the following occurs:
		  • Client has scarring of the opening of the foreskin making it non-retractable (pathological phimosis). This is unusual before five years of age. Phimosis must be treated with non-surgical methods (i.e., topical steroids) before circumcision is indicated.
		  • Documented recurrent, troublesome episodes of infection beneath the foreskin (balanoposthitis) that does not respond to other non-invasive treatments and/or sufficient hygiene
		  • Urinary obstruction
		  • Urinary tract infections

• **Maxillofacial/ cranial surgery**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Surgical services are only covered when done to restore physical function or to correct physical problems resulting from injuries or congenital defects.
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Medicaid does not cover these services for the following:
		  • Improvement of appearance or self-esteem (cosmetic)
		  • Dental implants
		  • Orthodontics

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Blepharoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Reconstructive blepharoplasty may be covered for the following:
		  • Correct visual impairment caused by drooping of the eyelids (ptosis)
		  • Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure)
		  • Treat periorbital sequelae of thyroid disease and nerve palsy
		  • Relieve painful symptoms of blepharospasm (uncontrollable blinking).
		• Documentation must include the following:
		  • Surgeon must document indications for surgery
		  • When visual impairment is involved, a reliable source for visual-field charting is recommended
		  • Complete eye evaluation
		  • Pre-operative photographs
		• Medicaid does not cover cosmetic blepharoplasty

• **Botox myobloc**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• The following are covered:
		  • Blepharospasm - Botox (Type A) only
		  • Strabismus - Botox (Type A only
		  • Cervical dystonia - Botox (Type A) and Myobloc (Type B)
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Botox/Myobloc is not covered for the following:
		  • Any cosmetic purposes
		  • Services that are not approved by the FDA

• **Excising excessive skin and subcutaneous tissue**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Required documentation includes the following:
		  • The referring physician and surgeon must document the justification for the resection of skin and fat redundancy following massive weight loss.
		  • The duration of symptoms of at least six months and the lack of success of other therapeutic measures
		  • Pre-operative photographs
		• This procedure is contraindicated for, but not limited to, individuals with the following conditions:
		  • Severe cardiovascular disease
		  • Severe coagulation disorders
		  • Pregnancy
		• Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a client's appearance.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Rhinoplasty septorhinoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• The following do not require PA:
		  • Septoplasty to repair deviated septum and reduce nasal obstruction
		  • Surgical repair of vestibular stenosis to repair collapsed internal valves to treat nasal airway obstruction
		• Medicaid covers rhinoplasty in the following circumstances:
		  • To repair nasal deformity caused by a cleft lip/cleft palate deformity for clients 18 years of age and younger
		  • Following a trauma (e.g. a crushing injury) which displaced nasal structures and causes nasal airway obstruction.
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Not covered
		  • Cosmetic rhinoplasty done alone or in combination with a septoplasty
		  • Septoplasty to treat snoring

• **Temporomandibular joint (TMJ) arthroscopy/ surgery**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Non-surgical treatment for TMJ disorders must be utilized **first** to restore comfort and improve jaw function to an acceptable level. Non-surgical treatment may include the following in any combination depending on the case:
		  • Fabrication and insertion of an intra-oral orthotic
		  • Physical therapy treatments
		  • Adjunctive medication
		  • Stress management
		• Surgical treatment may be considered when both of the following apply:
		  • Other conservative treatments have failed (must be documented), and chronic jaw pain and dysfunction have become disabling. Conservative treatments must be utilized for six months before consideration of surgery.
		  • There are specific, severe structural problems in the jaw joint. These include problems that are caused by birth defects, certain forms of internal derangement caused by misshapen discs, or degenerative joint disease. For surgical consideration, arthrogram results must be submitted for review.
		• Not covered:
		  • Botox injections for the treatment of TMJ are considered experimental.
		  • Orthodontics to alter the bite
		  • Crown and bridge work to balance the bite
		  • Bite (occlusal) adjustments

• **Partial hospitalization**	First Health Services 4300 Cox Road Glen Allen, VA 23060 **Phone:** (800) 770-3084 **Fax:** (800) 639-8982 Fax (800) 247-3844 Fax	• A certificate of need must be completed, signed, and dated no more than 30 days prior to the date of admission. • The certificate must be completed by a team of health care professionals that have competence in the diagnosis and treatment of mental illness and the patient's psychiatric condition.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements
• **Dermabrasion/ abrasion chemical peel**	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953 **Phone:** For clients with last names beginning with **A - L**, call: (406) 444-3993 In/out-of-state For clients with last names beginning with **M - Z**, call: (406) 444-0190 In/out-of-state **Fax:** (406) 444-0778	• Services covered for the following: • Treating severe, deep acne scarring not responsive to conservative treatment. All conservative treatments must have been attempted and documented for at least six months before medical necessity is determined. • The removal of pre-cancerous skin growths (keratoses) • Documentation requirements include a letter from the attending physician documenting: • Client's condition • Proposed treatment • Reason treatment is medically necessary • Pre-operative photographs
• **Positron emission tomography (PET) scans**	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953 **Phone:** For clients with last names beginning with **A - L**, call: (406) 444-3993 In/out-of-state For clients with last names beginning with **M - Z**, call: (406) 444-0190 In/out-of-state **Fax:** (406) 444-0778	• PET scans are covered for the following clinical conditions: (For more details on each condition and required documentation, contact the SURS unit.) • Solitary pulmonary nodules (SPNs) - characterization • Lung cancer (non small cell) - Diagnosis, staging, restaging • Esophageal cancer - Diagnosis, staging, restaging • Colorectal cancer - Diagnosis, staging, restaging • Lymphoma - Diagnosis, staging, restaging • Melanoma - Diagnosis, staging, restaging. Not covered for evaluating regional nodes • Breast cancer - As an adjunct to standard imaging modalities for staging clients with distant metastasis or restaging clients with locoregional recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring tumor response to treatment for women with locally and metastatic breast cancer when a change in therapy is anticipated • Head and neck cancers (excluding central nervous system and thyroid) - Diagnosis, staging, restaging • Myocardial viability - Primary or initial diagnosis, or following an inconclusive SPECT prior to revascularization. SPECT may not be used following an inconclusive PET scan. • Refractory seizures - Covered for pre-surgical evaluation only. • Perfusion of the heart using Rubidium 82 tracer (Not DFG-PET) - Covered for noninvasive imaging of the perfusion of the heart.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Reduction mammoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT
	59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/ out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/ out-of-state
	
	Fax:
	(406) 444-0778
		• Both the referring physician and the surgeon must submit documentation.
		• Back pain must have been documented and present for at least six months, and causes other than breast weight must have been excluded.
		• **Indications for female client:**
		• Contraindicated for pregnant women and lactating mothers. A client must wait six months after the cessation of breast feeding before requesting this procedure.
		• Female client 16 years or older with a body weight less than 1.2 times the ideal weight.
		• There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a six month period. This must include at least two of the following conditions:
		  • Upper back, neck, shoulder pain that has been unresponsive to at least six months of documented and supervised physical therapy and strengthening exercises
		  • Paresthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted.
		  • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy.
		  • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back.
		Documentation in the client's record must indicate and support the following:
		• History of the client's symptoms related to large, pendulous breasts.
		• The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain, etc.).
		• Guidelines for the anticipated weight of breast tissue removed from each breast related to the client's height (which must be documented):
		Height — **Weight of tissue per breast**
		less than 5 feet — 250 grams
		5 feet to 5 feet, 2 inches — 350 grams
		5 feet, 2 inches to 5 feet, 4 inches — 450 grams
		greater than 5 feet, 4 inches — 500 grams
		• Pre-operative photographs of the pectoral girdle showing changes related to macromastia.
		• Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery.
		• **Indications for male client:**
		• If the condition persists, a client may be considered a good candidate for surgery. Clients who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first.
		• Documentation required: length of time gynecomastia has been present, height, weight, and age of the client, pre-operative photographs

Other Programs

Clients who are enrolled in the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP) are not enrolled in PASSPORT, so the PASSPORT requirements in this chapter do not apply. However, prior authorization may be required for certain services. Refer to the *Mental Health* manual.

For more CHIP information, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. Additional CHIP information is available on the Provider Information website (see *Key Contacts*).

- Orphan drugs
- Radiopharmaceuticals
- Certain other drugs, such as those provided in an emergency department for heart attacks

Medicare does not cover revenue code 250 (General class pharmacy). When a client has both Medicare and Medicaid and Medicare denies the pharmacy portion of a claim, providers must report revenue code 250 on a separate UB-92 claim form when submitting the claim to Medicaid.

Lab services

If all tests that make up an organ or disease organ panel are performed, the panel code should be billed instead of the individual tests.

Some panel codes are made up of the same test or tests performed multiple times. When billing one unit of these panels, bill one line with the panel code and one unit. When billing multiple units of a panel (the same test is performed more than once on the same day), bill the panel code with units corresponding to the number of times the panel was performed.

Outpatient clinic services

When Medicaid pays a hospital for outpatient clinic or provider based clinic services, the separate CMS-1500 claim for the physician's services must show the hospital as the place of service (i.e., place of service is 22 for hospital outpatient). For imaging and other services that have both technical and professional components, physicians providing services in hospitals must also take care to bill only for the professional component if the hospital will bill Medicaid for the technical component. Refer to the *Physician Related Services* manual, *Billing Procedures* chapter for more information. Manuals are available on the Provider Information website (see *Key Contacts*)

Partial hospitalization

Partial hospitalization services must be billed with the national code for partial hospitalization, the appropriate modifier, and the prior authorization code.

Current Payment Rates for Partial Hospitalization

Code	Modifier	Service Level
H0035		Partial hospitalization, sub-acute, half day
H0035	U6	Partial hospitalization, sub-acute, full day
H0035	U7	Partial hospitalization, acute, half day
H0035	U8	Partial hospitalization, acute, full day

Sterilization

- For elective sterilizations, a completed *Informed Consent to Sterilization* (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.
- For medically necessary sterilizations (including hysterectomies), one of the following must be attached to the claim, or payment will be denied:
    - A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39) for each provider submitting a claim. See *Appendix A Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client must sign and date this form at least 30 days prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). The client does not need to sign this form when sections B or C are used. Please refer to *Appendix A* for more detailed instructions on completing the form.
    - For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
        - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
        - The reason for the hysterectomy was a life-threatening emergency.
        - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

For more information on sterilizations, see the *Covered Services* chapter in this manual.

Supplies

Supplies are generally bundled (packaged), so they usually do not need to be billed individually. A few especially expensive supplies are paid separately by Medicaid. Documentation of the Ambulatory Payment Classification (APC) system, available from commercial publishers, lists the supply codes that may be separately payable.

Submitting a Claim

Paper claims

Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Electronic claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ACS field software WINASAP 2003. ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department.
- ACS clearinghouse. Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway.
- Clearinghouse. Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway

For more information on electronic claims submission, contact Provider Relations or ACS EDI Gateway (see *Key Contacts*).

Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibiligy, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete the top portion of the form with the provider's name and address. If you are including a copy of the claim, complete side A; if a copy of the claim is not included, complete side B.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a **7-digit** number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, hand-written, or computer generated.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a UB-92 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client, verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual. Medicaid eligibility may change monthly.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim form when such approval is required. PASSPORT approval is different from prior authorization. See the *PASSPORT and Prior Authorization* chapter in this manual.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim form. Prior authorization is different from PASSPORT authorization. See the *PASSPORT and Prior Authorization* chapter in this manual).
Prior authorization does not match current information	• Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see *Remittance Advices and Adjustments* in this manual).
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.
Missing Medicare EOMB	All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper.
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated	• Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Procedure is not allowed for provider type	• Provider is not allowed to perform the service. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

The billing procedures in this chapter apply to those services that are covered under the Mental Health Services Plan (MHSP). These billing procedures do not apply to the Children's Health Insurance Plan (CHIP). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Instructions for Completing the *Informed Consent to Sterilization* (MA-38)

- No fields on this form may be left blank, except the interpreter's statement.
- This form must be legible, accurate, and revisions are not accepted.
- Do not use this form for hysterectomies (see following *Hysterectomy Acknowledgment* form.)

Consent to Sterilization (complete at least 30 days prior to procedure)

1. Enter the doctor's name or clinic name.
2. Enter the name of the sterilization procedure (e.g., tubal ligation, vasectomy, etc.).
3. Enter the client's date of birth in month/day/year format. The client must be at least 21 years old at the time of consent.
4. Enter the client's full name. Do not use nicknames. The name should match the client's name on the Medicaid ID card.
5. Enter the name of the physician who will perform the procedure.
6. Enter the name of the specific procedure (method) to be used.
7. Have the client sign and date the form. **This date must be at least 30 days before the sterilization procedure is to be performed** (see *Covered Services* for exceptions).

Interpreter's Statement

Complete this section only if the client requires an interpreter because of blindness, deafness, or inability to speak the language. In these cases interpreter services must be used to assure that the client clearly understands the concepts of the informed consent.

1. Identify the manner the interpreter used to provide the explanation. (e.g., Spanish, sign language, etc.)
2. Have the interpreter sign and date the form. This date should be the same as the date the client signs the form.

Statement of Person Obtaining Consent

1. Enter the client's name.
2. Enter the name of the sterilization procedure.
3. Enter the signature and date of the person who explained the sterilization procedure to the client and obtained the consent.
4. Enter the name of the facility where consent was obtained, such as clinic name.
5. Enter the address of the facility where the consent was obtained.

Physician's Statement

This section must be completed by the attending physician on or after the date the procedure was performed.

1. Enter the name of the client.
2. Enter the date the procedure was performed. This date and the date of service on the claim must match.
3. Enter the name of the procedure.
4. Use the space under *Instructions for use of alternative final paragraphs* to explain unusual situations, or attach a letter to explain the circumstances. In cases of premature delivery, this must include the client's expected date of delivery. In cases of emergency abdominal surgery, include an explanation of the nature of the emergency.
5. The Physician signs and dates on or after the date of the procedure.

If the physician signs and dates this section prior to the sterilization procedure, the claims will be denied. If the form was filled out after the sterilization but was dated incorrectly, the physician must attach a written explanation of the error. This written explanation must be signed by the physician. Copies of the letter will need to be supplied to all other providers involved with this care before their claims will be paid.

The attending physician must complete the second *alternative final paragraphs* of the Physician's Statement portion of the consent form in cases of premature deliver or emergency abdominal surgery. In cases of premature delivery, the expected delivery date must be completed in this field as well.

MEDICAID HYSTERECTOMY ACKNOWLEDGMENT

A. RECIPIENT ACKNOWLEDGMENT STATEMENT

I certify that prior to the surgery (hysterectomy), I received both orally and in writing information which explained that I would become permanently sterile and that I would be incapable of reproducing children after the surgery is completed.

Signature of Recipient: _____ Date: _____

PHYSICIAN ACKNOWLEDGMENT STATEMENT

I certify that prior to performing the surgery, I advised _____ *(Name of Recipient)* both orally and in writing that the surgical procedure known as a hysterectomy would render her permanently sterile and that she would be incapable of reproducing children after the surgical procedure is completed. I also certify that this procedure is being done primarily for medical reasons other than sterilization.

Signature of Physician: _____ Date: _____

SIGNATURE OF INTERPRETER (If Required)

Signature of Interpreter: _____ Date: _____

B. STATEMENT OF PRIOR STERILITY

I certify that _____ *(Name of Recipient)* was already sterile and unable to bear children at the time the hysterectomy or other procedure capable of causing sterility was performed. The cause of this recipient's sterility was: _____

_____

_____

Signature of Physician: _____ Date: _____

C. STATEMENT OF LIFE THREATENING EMERGENCY

I certify that the hysterectomy or other sterility causing procedure performed on _____ *(Name of Recipient)* was completed under a life threatening emergency situation in which prior acknowledgment was not possible. The nature of the emergency was _____

_____

_____

Signature of Physician: _____ Date: _____

This form may also be used as a substitute for the sterilization consent form for sterilization procedures where the patient is already sterile and for sterilization procedures (i.e., salpingo-oophorectomy, orchiectomy) done only for medical reasons. With these cases, replace "hysterectomy" with the appropriate procedure name.

Instructions for Completing the *Medicaid Hysterectomy Acknowledgment* Form (MA-39)

Complete only one section (A, B, or C) of this form. The client does not need to sign this form when sections B or C are used. This form may be used as a substitute for the *Informed Consent to Sterilization* form for sterilization procedures where the client is already sterile, and for sterilization procedures (i.e. salpingo-oophorectomy, orchiectomy, etc.) done only for medical reasons. In these cases, replace the word "hysterectomy" with the appropriate procedure name.

A. Recipient Acknowledgment Statement

This section is used to document that the client received information about the hysterectomy before it was performed. The client and the physician complete this portion of the form together with an interpreter if applicable. The client must sign and date this form at least 30 days prior to the hysterectomy. Do **not** use this section for cases of prior sterility or life-threatening emergency.

1. The client or her representative must sign and date the form at least 30 days prior to the procedure.
2. Enter the client's name.
3. The physician must sign and date the form.
4. If interpreter services are used, the interpreter must sign and date the form at least 30 days prior to the procedure.

B. Statement of Prior Sterility

Complete this section if the client was already sterile at the time of her hysterectomy or other sterilization causing procedure (e.g., salpingo-oophorectomy or orchiectomy).

1. Enter the client's name.
2. Explain the cause of the client's sterility (e.g., post menopausal, post hysterectomy, etc.).
3. The physician must sign and date this portion of the form.

C. Statement of Life Threatening Emergency

Complete this section in conjunction with Section A in cases where the *Medicaid Hysterectomy Acknowledgment* could not be completed prior to the surgery because of a life threatening emergency.

1. Enter the client's name.
2. Explain the nature of the life-threatening emergency.
3. The physician must sign and date this portion of the form.

Montana Medicaid Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____	ACS Response: _____
Client number _____	
Date of service _____	
Total billed amount _____	
Date submitted for processing _____	
Provider number _____	ACS Response: _____
Client number _____	
Date of service _____	
Total billed amount _____	
Date submitted for processing _____	
Provider number _____	ACS Response: _____
Client number _____	
Date of service _____	
Total billed amount _____	
Date submitted for processing _____	

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402